

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13623

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 13595

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> c. LENGTH OF STAY IN 1b <u>8 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> d. STREET ADDRESS <u>Main Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Martha</u> Middle <u>B</u> Last <u>Abrahams</u> <b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>23</u> Year <u>19 59</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11-27-1870</u> <b>9. AGE</b> (In years last birthday) <u>89</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>North East, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>Thomas C. McCracken</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Browne</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u> <b>16. SOCIAL SECURITY NO.</b> <u>-</u> <b>17. INFORMANT</b> <u>Howard Abrahams</u> Address <u>North East, Maryland</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Interstitial Cystitis</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>				<b>20c. TIME OF INJURY</b> Month <u>-</u> Day <u>19</u> Year <u>19</u> Hour a. m. _____ p. m. _____ <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-</u> <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that I attended the deceased from</b> <u>June</u> , 19 <u>58</u> , to <u>23 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>23 Dec</u> , 19 <u>59</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <u>Klaus H. Huebner</u> M.D. <u>North East, Md</u> <b>DATE SIGNED</b> <u>12/23/59</u> <b>PHYSICIAN'S NAME (Type)</b> <u>Klaus H. Huebner</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12-26-1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>North East Methodist</u>		<b>22d. LOCATION (City, town, or county)</b> <u>North East, Cecil Co., Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant</u> ADDRESS <u>North East, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>DEC 28 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13614

## CERTIFICATE OF DEATH

Reg. Dist. No.

13596

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 ELKTON</u>		d. STREET ADDRESS <u>323 Curtis Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lydia</u> First <u>GREENE</u> Middle <u>Bailey</u> Last		4. DATE OF DEATH <u>12</u> Month <u>8</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1878</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John GREENE</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ALLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-847</u>	
17. INFORMANT <u>MARTHA WALLS</u> Address <u>323 Curtis Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Disease</u> DUE TO (c) <u>Chronic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 yr.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 1959, to <u>Dec 1</u> , 1959, that I last saw the deceased alive on <u>12/3/59</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12/8/59</u> DATE SIGNED <u>Edward J. Greenwald M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CECILTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CECILTON, Cecil Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Greenwald M.D.</u> ADDRESS <u>Millington, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
SIGNATURE OF REGISTRAR		SIGNATURE OF MINISTER	
OFFICIAL SEAL		OFFICIAL SEAL	

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
1910

13615

CERTIFICATE OF DEATH

Reg. Dist. No.

13597

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Md.</u>				c. LENGTH OF STAY IN 1b <u>1 Week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Colora Md. Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Nursing Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Levie Hoag Balderston</u>				4. DATE OF DEATH Dec. 26, 19 59			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 / 8 / 1891</u>		9. AGE (In years last birthday) yrs. <u>68</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Balderston</u>				14. MOTHER'S MAIDEN NAME <u>Myra Atwater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>300-01-9337</u>		17. INFORMANT Address <u>Mrs. Anna Balderston Colora, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anteriorly to Cultural does as Profusion's Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 19</u> , 19 <u>59</u> , to <u>Dec. 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 26</u> , 19 <u>59</u> , and that death occurred at <u>150A</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>232 B MAIN ST. ELKTON, MARYLAND</u> DATE SIGNED <u>12/26/59</u>							
ACTUAL SIGNATURE <u>S. Ralph Andrews Jr</u> M.D.		PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS JR. MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friends-Burial</u>		22d. LOCATION (City, town, or county) (State) <u>Colora Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman E. M. - Melba Rising Sun Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clarence S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1950

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13598  
Reg. Dist. No.

13624

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake</b>	c. LENGTH OF STAY IN 1b <b>all life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dr. H.V. Davis Office</b>		e. STREET ADDRESS <b>Canal St.</b>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Timothy Banks</b>		4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-58</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James D. Bedwell</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Ellen Banks</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Mrs. Mary E. Bedwell, Chesapeake City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub dural hemorrhage</b> <b>9040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell backwards and hit the floor</b>			INTERVAL BETWEEN ONSET AND DEATH
20c. TIME OF INJURY Month, Day, Year <b>9 15 a. m. 12 8 19 59</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			20f. (City or town) (County) (State) <b>Chesapeake City Cecil Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>12-8-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC. 10, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BETHEL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>NR. CHESAPEAKE CITY Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>ELKTON Md.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BACINOR 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of \_\_\_\_\_ State of \_\_\_\_\_  
Date of Death \_\_\_\_\_

Decedent's Name \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_

Residence \_\_\_\_\_  
Occupation \_\_\_\_\_

Place of Death \_\_\_\_\_  
Cause of Death \_\_\_\_\_

Time of Death \_\_\_\_\_  
Manner of Death \_\_\_\_\_

Signature of Medical Examiner \_\_\_\_\_  
Title \_\_\_\_\_

Signature of Coroner \_\_\_\_\_  
Title \_\_\_\_\_

Signature of \_\_\_\_\_  
Title \_\_\_\_\_

Signature of \_\_\_\_\_  
Title \_\_\_\_\_

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Title \_\_\_\_\_

Signature of \_\_\_\_\_  
Title \_\_\_\_\_



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G253 12-11-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

13599

13625

1. PLACE OF DEATH a. COUNTY <b>Oecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Penna.</b> b. COUNTY <b>Chester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nottingham</b>	
c. LENGTH OF STAY IN 1b <b>9 Days</b>		d. STREET ADDRESS <b>Rt #2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>V. A. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>ROY R. CAMPBELL</b>			4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-20</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Aberdeen Pr Gnd</b>	11. BIRTHPLACE (State or foreign country) <b>Nottingham, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME <b>Clarence Campbell</b>	14. MOTHER'S MAIDEN NAME <b>Ida McCall</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW II 198-10-5720</b>	INFORMANT <b>V. A. Hospital, Perry Point, Md.</b>	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG - Anaplastic</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that <del>the deceased died</del> that death occurred at <b>9:35 A.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>J. L. Garey</b>	DATE SIGNED <b>VAH, Perry Point, Md.</b>
PHYSICIAN'S NAME (Type) <b>J. L. GAREY, MD</b> <b>Clinical Pathologist.</b>	

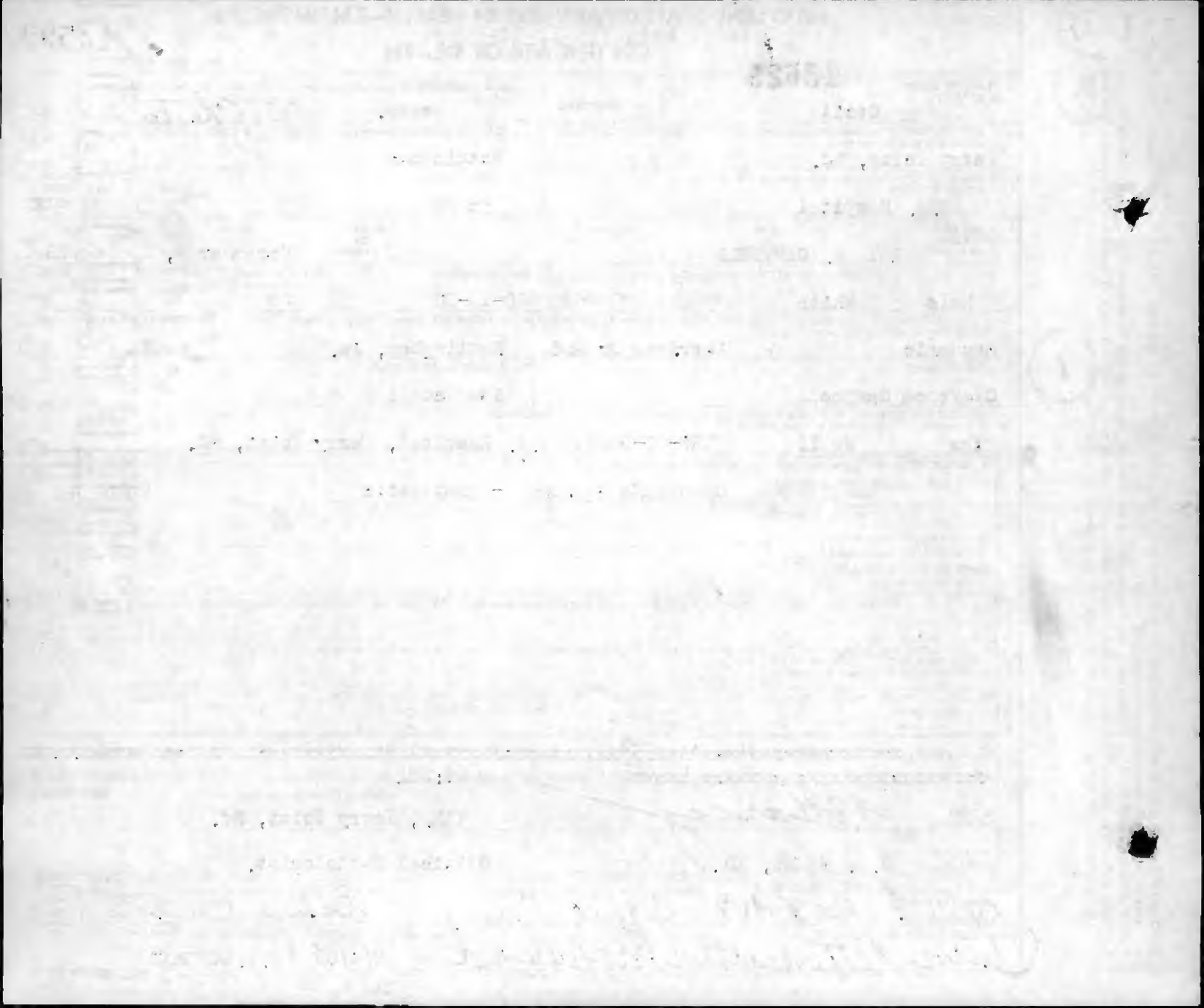
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>Dec 8 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Oxford, Chester Co. Pa.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>L. W. Patterson</b>	24a. REC'D BY REGISTRAR <b>12/4/59</b>	24b. REGISTRAR'S SIGNATURE <b>J. M. LOKEMAN</b>
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DEC 9 '59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

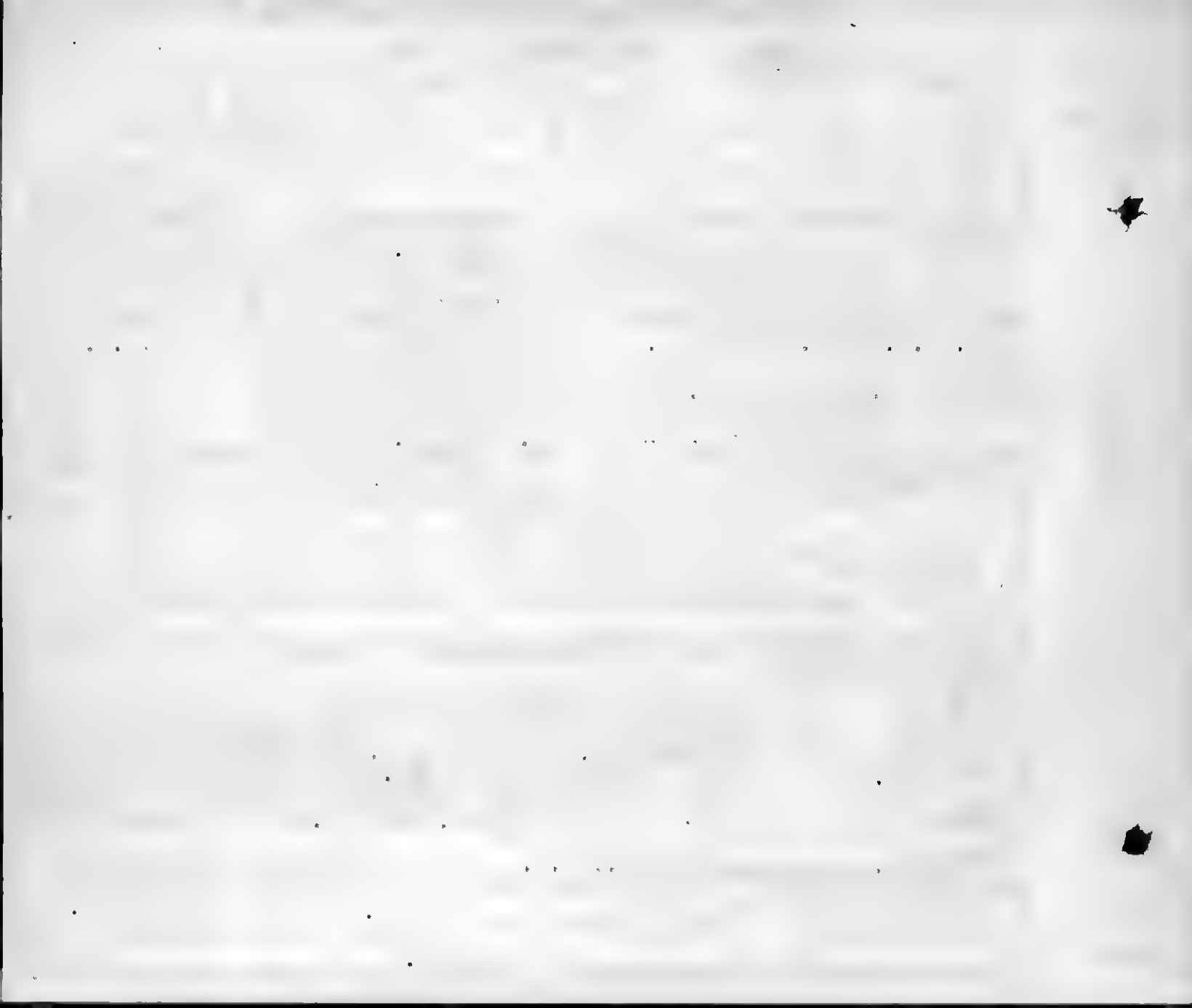
13626

## CERTIFICATE OF DEATH

Reg. Dist. No.

13600

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pip-in Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Zachary First Middle Last Taylor Cooling, Jr.				4. DATE OF DEATH Month Day Year Dec. 12, 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 23, 1830	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Govt.		11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachary T. Cooling, Sr.				14. MOTHER'S MAIDEN NAME Josephine Loveless			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 169-20-1427		17. INFORMANT Mrs. Marie S. Cooling, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic carcinoma with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH about 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 30, 1959</u> to <u>Dec. 12, 1959</u> , that I last saw the deceased alive on <u>Dec. 8, 1959</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				ADDRESS (Street, city or town, state) M.D. 233 E. Main St.		DATE SIGNED 12/12/59	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/59		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pip-in Funeral Home				ADDRESS Elkton		24c. REC'D BY REGISTRAR DATE DEC 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13627

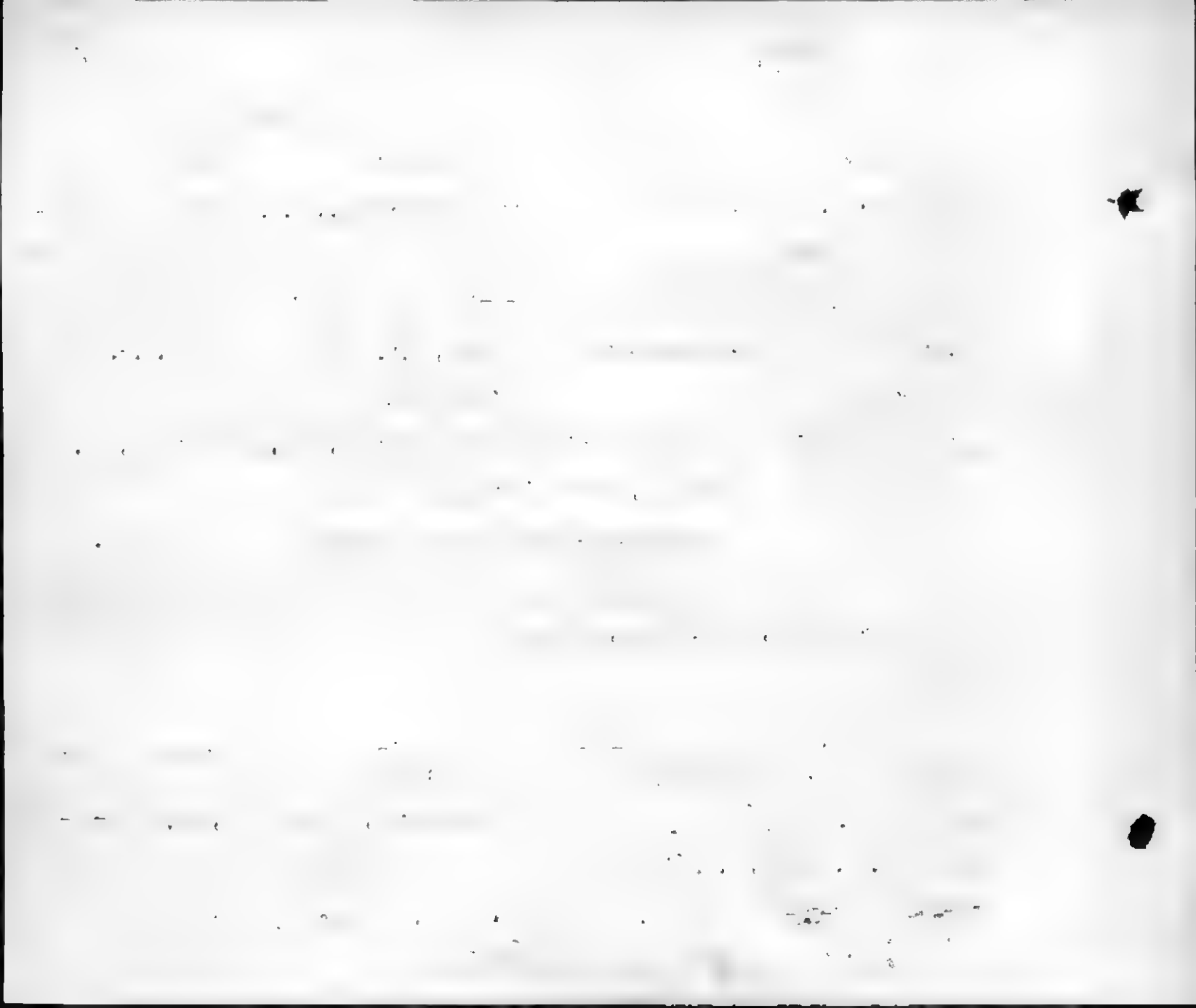
## CERTIFICATE OF DEATH

Reg. Dist. No.

13601

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>15 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47x</b> d. STREET ADDRESS <b>607 Ancosita Ave., N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James H Gornnor</b>		4. DATE OF DEATH Month Day Year <b>12 12 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-15</b>
9. AGE (In years last birthday) yrs. <b>44</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>7 days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not Ascertainable</b>	
11. BIRTHPLACE (State or foreign country) <b>Copes, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Gornnor</b>		14. MOTHER'S MAIDEN NAME <b>Katie Kitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>Not Ascertainable</b>	
17. INFORMANT <b>VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Azotemia, uremia (Clinical)</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) <b>Unkn.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, severe</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 11-27-19 59</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-27-19 59</b> to <b>12-12-19 59</b> and that death occurred at <b>10:35A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA Hospital, Perry Point, Md.</b> DATE SIGNED <b>12-12-59</b>			
ACTUAL SIGNATURE <b>J. L. Garey</b>		M.D. <b>VA Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-16-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Ceme.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Stewart</b>		24a. REC'D BY REGISTRAR <b>30-H STATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		DATE <b>DEC 16 '59</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

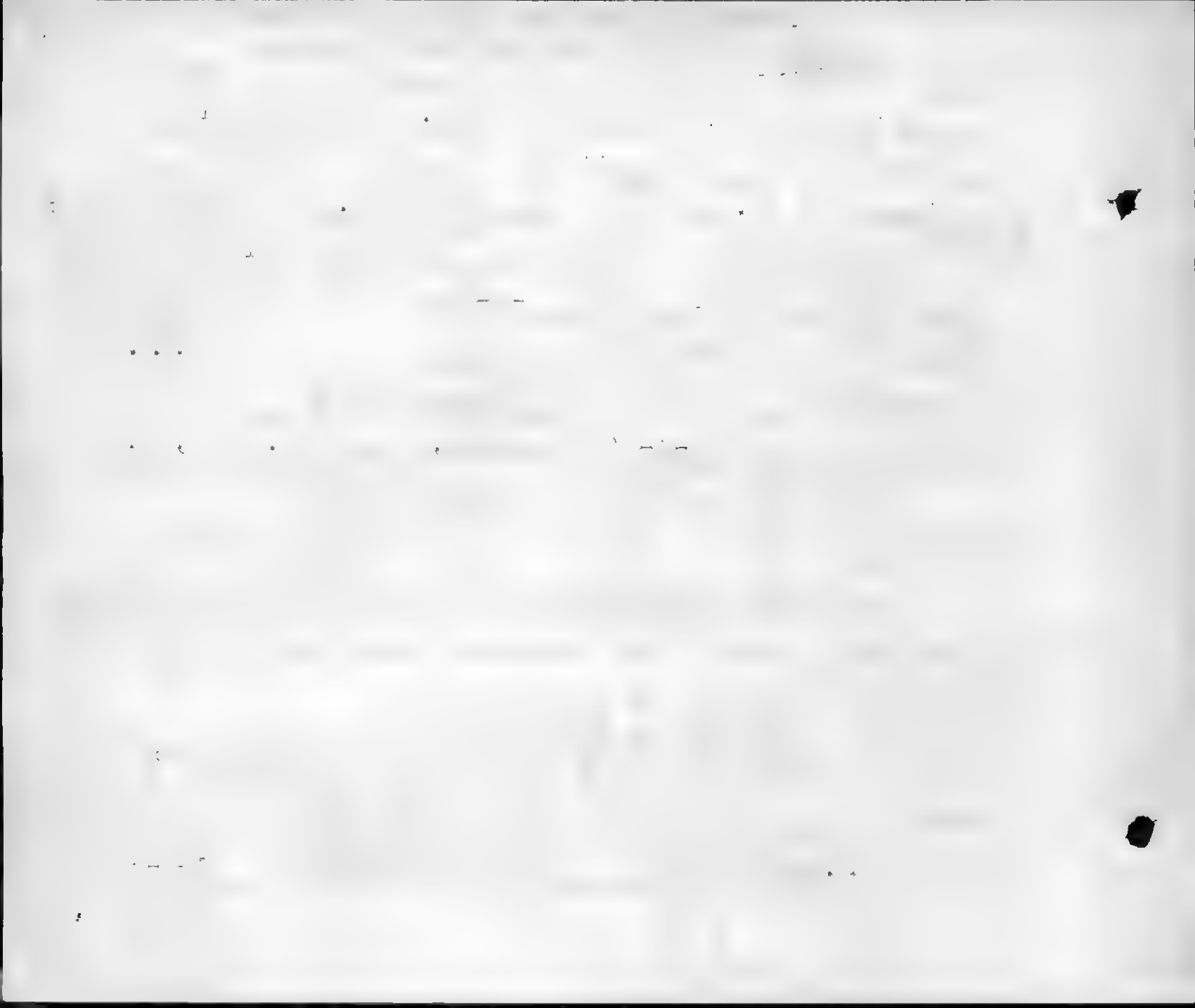
13602

13615

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>all life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>520 North St.</b>				e. STREET ADDRESS <b>520 North St.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>O</b> Last <b>Dean</b>				4. DATE OF DEATH Month <b>12</b> Day <b>2</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-11-1870</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months <b>89</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ship Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Dean</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Oliver</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>222-07-0228</b>		17. INFORMANT Address <b>Ralph Dean, 520 North St. Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (c), stating the underlying cause last. DUE TO (c) <b>420.1</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-2-59</b>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIEN FUNERAL HOME</b>				ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13608

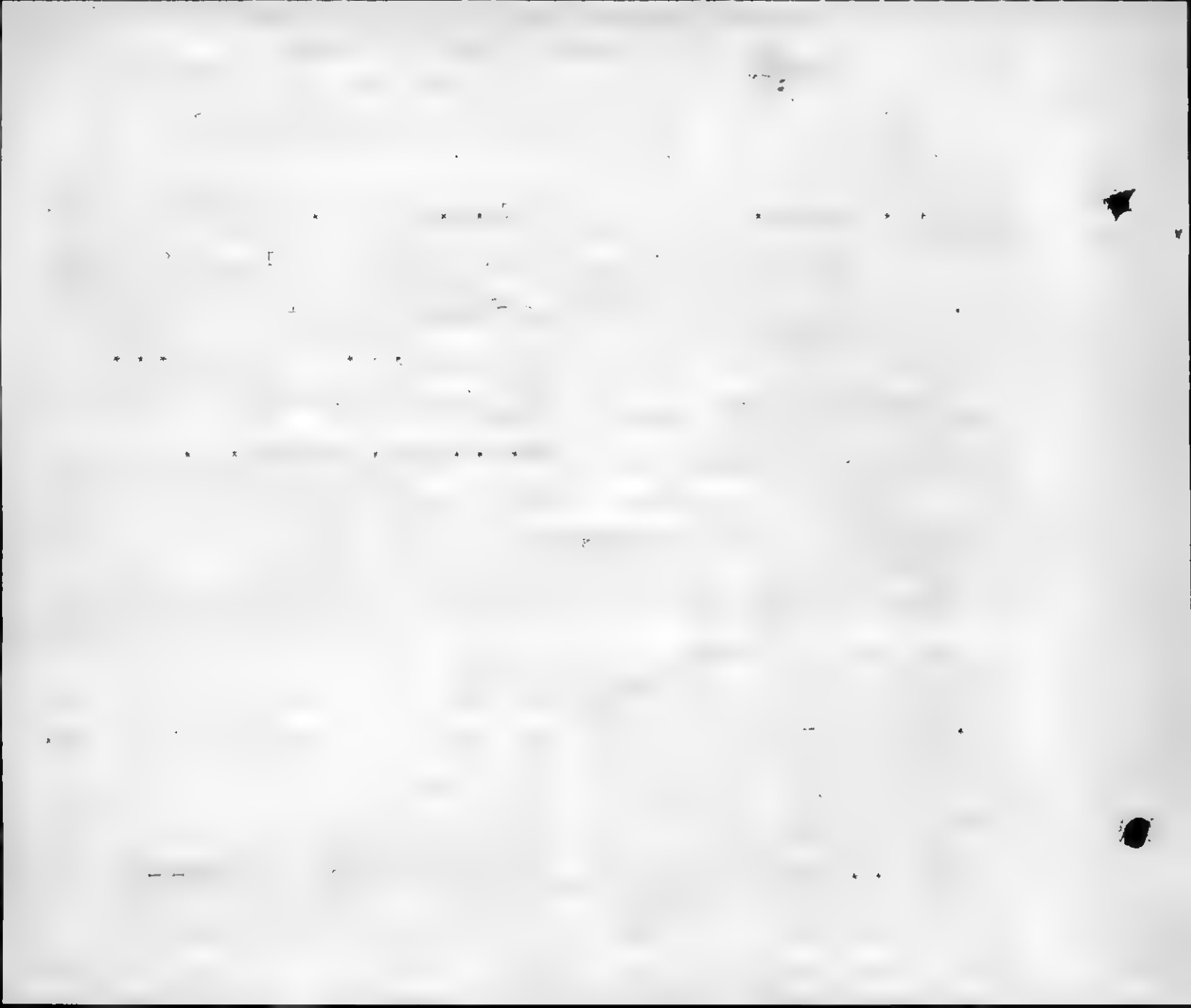
Reg. Dist. No.

13628

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>		c. LENGTH OF STAY IN 1b <b>22 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>13. S. Walnut St.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>	
3. NAME OF DECEASED (Type or print) <b>Cornelia McChesney Dunn</b>		d. STREET ADDRESS <b>13. S. Walnut St.</b>	
4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1959</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-8-1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Abingdon, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Samuel Haney</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Craig Dunn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. R.C. Dodson</b>		Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fracture Left femur</b> <b>9040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Chronic Myocarditis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at side of bed</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:30</b> o. m. <b>12-9</b> 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rising Sun Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sinking Springs Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Abingdon</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earle Tyson</b>		24a. REC'D BY REGISTRAR <b>DEC 11 '59</b>	
ADDRESS <b>Rising Sun, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Orlana S. Hand</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

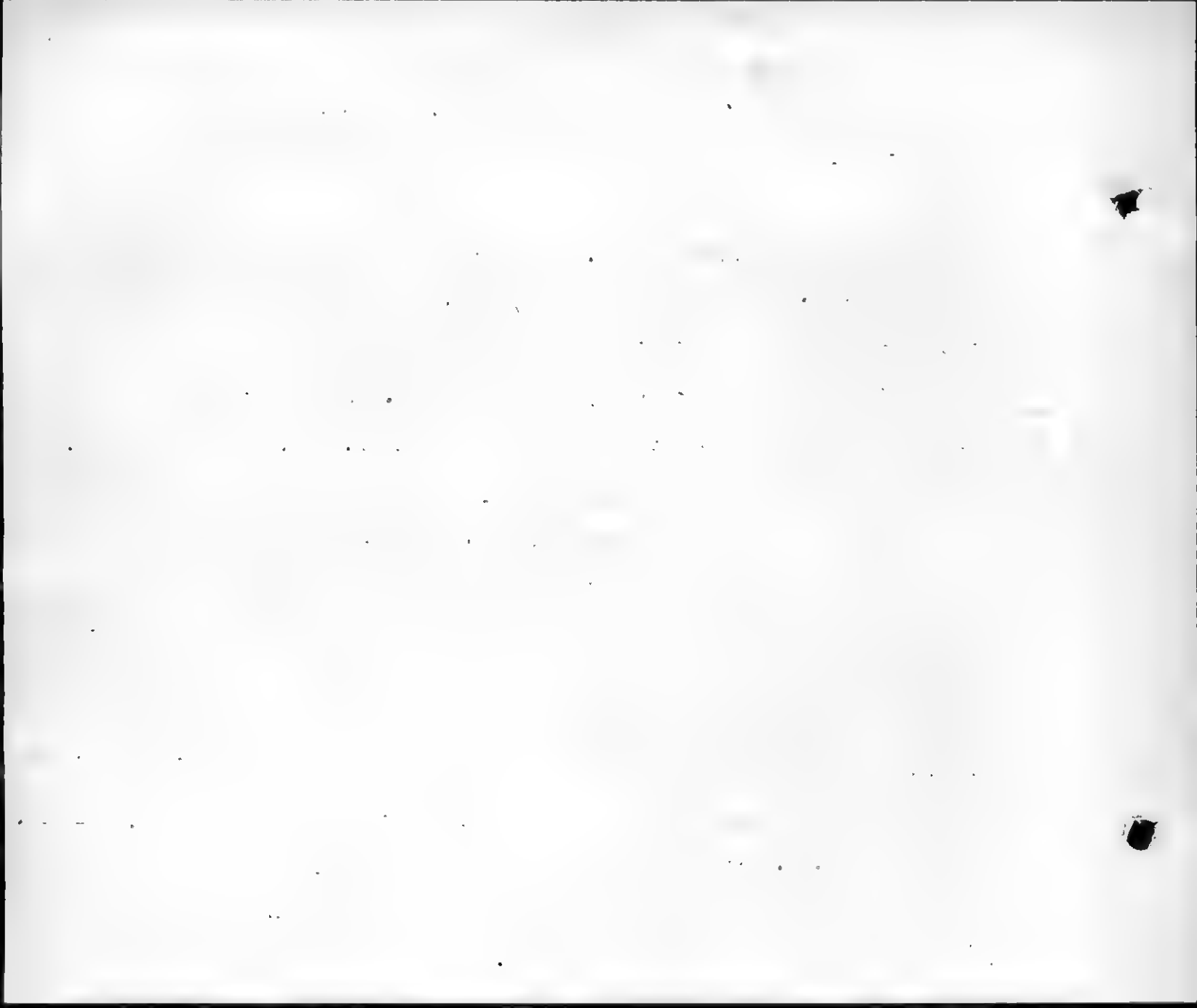
Reg. Dist. No. 96

13629

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>5 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>New York City, New York</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New York City</b> d. STREET ADDRESS <b>10 Stuyvesant Oval</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHLEEN M. FAHEY</b>		4. DATE OF DEATH Month Day Year <b>December 17 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/30/09</b>
9. AGE (In years last birthday) <b>50</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Michael Fahey (Deceased)</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Daly (deceased)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO <b>WW II</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>583X</b> IMMEDIATE CAUSE (a) <b>Hepato-renal syndrome</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO (c) <b>Cerebral hemorrhage due to jaundice</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 17 1959</b> to <b>December 17 1959</b> and that death occurred at <b>2:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>V.A. Hospital, Perry Point, Md. 12-18-59</b>			
ACTUAL SIGNATURE <b>L. G. CIAN</b> PHYSICIAN'S NAME (Type) <b>Staff Surgeon</b>		22a. BURN, CREMATION, REMOVAL (Specify) <b>12/19/59</b>	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	
22d. LOCATION (City, town, or county) (State) <b>New York</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 96

13605

13630

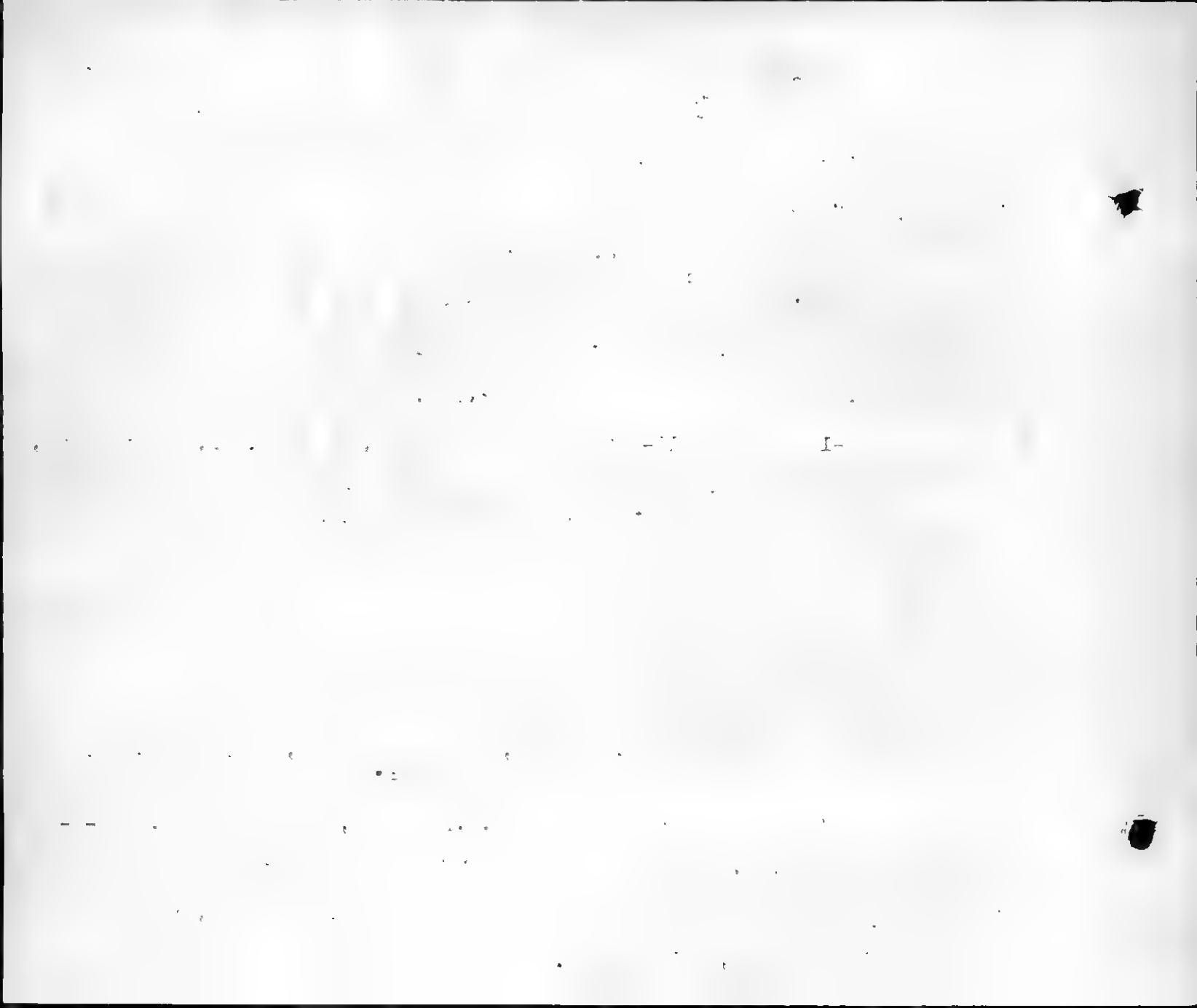
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILSON</b> Middle <b>J.</b> Last <b>GRAFTON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1896</b>
9. AGE (In years last birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paperhanger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Remodeling</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN A. GRAFTON</b>		14. MOTHER'S MAIDEN NAME <b>ANNE E. THOMAS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>Yes</b> <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>219-14-2461</b>	
17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the rectum with obstruction of the terminal ileum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>obstruction of the terminal ileum</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 1, 1959</b> to <b>December 1, 1959</b> , and that death occurred at <b>12:15 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>12-1-59</b>			
ACTUAL SIGNATURE <b>J. L. GAREY</b>		M.D. <b>V.A. Hospital, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-4-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Centre Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Forrest Hills, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HARKINS FUNERAL HOME, Delta, Penna.</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13617

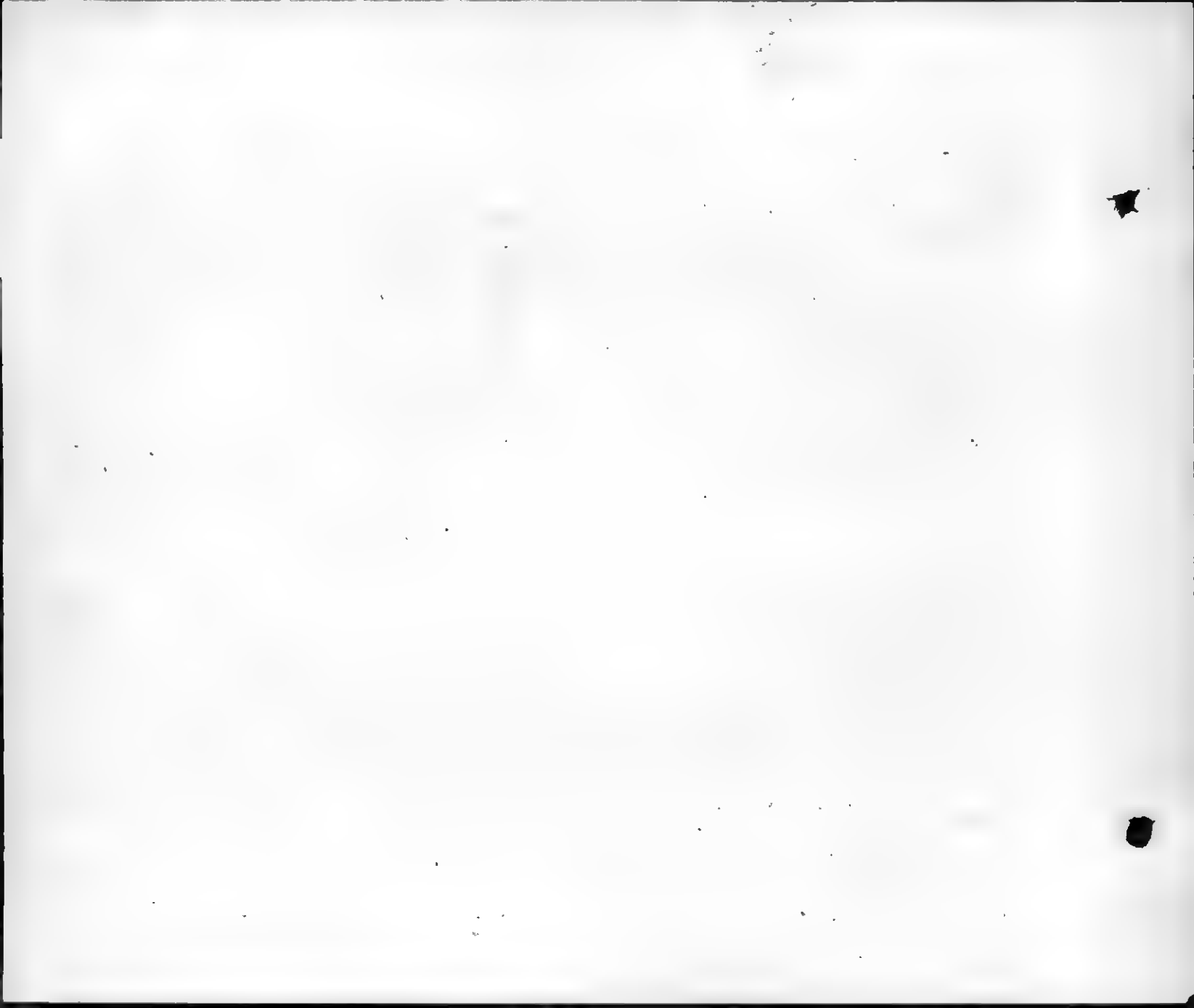
CERTIFICATE OF DEATH

Reg. Dist. No. 13606

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON				c. LENGTH OF STAY IN 1b 5 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY JANE Middle HAMMOND Last				4. DATE OF DEATH Month 12 Day 17 Year 1959			
5 SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1904		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL MEDKEFF				14. MOTHER'S MAIDEN NAME IDA MAY BELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. LILLIAN BYWATER SEATTLE, WASH.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 527.0 DUE TO Post-operative Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/6 1959 to 12/17 1959, that I last saw the deceased alive on 12/17 1959, and that death occurred at 5:50 P. M. from the causes and on the date stated above.							
SIGNATURE John A. Fischer M.D.				ADDRESS (Street, city or town, state) 162 W. MAIN ST. ELKTON, MD			
DATE SIGNED 12/18/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC 23, 1959		22c. NAME OF CEMETERY OR CREMATORY CHERRY HILL		22d. LOCATION (City, town, or county) (State) CHERRY HILL, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PAPPIN FUNERAL HOME 1001 N. D. ELKTON, MD				24a. REC'D BY REGISTRAR DATE DEC 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

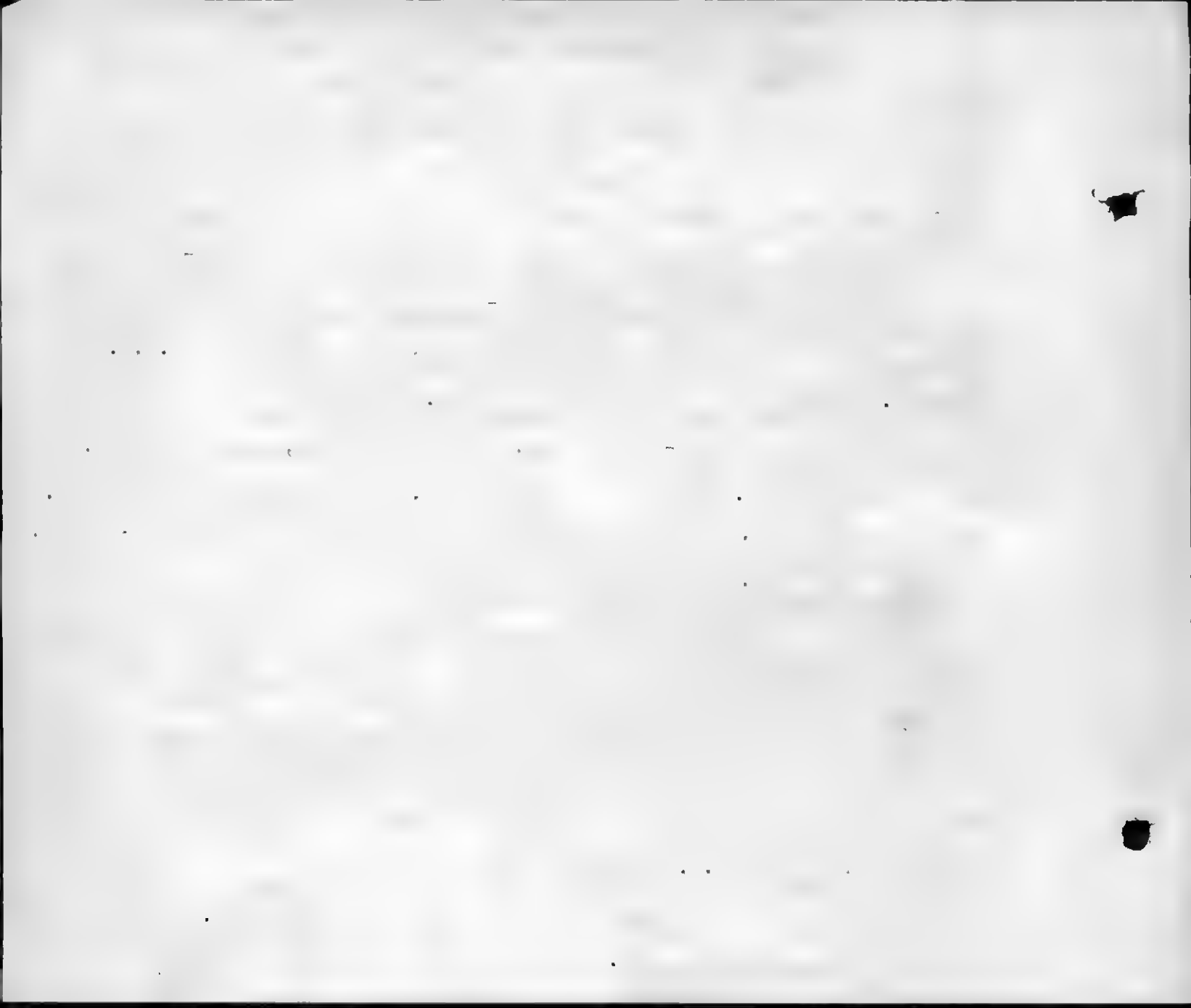
Reg. Dist. No. 96

13607

13631

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>5 minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VAH, Perry Point, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X North East</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) <b>WILLIAM Harry HOFFMAN</b>				4. DATE OF DEATH Month Day Year <b>12-15 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5-8-83</b>	
9. AGE (in years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Regular laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Pickway, Pennsylvania</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel W. Hoffman</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Alexander</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-1</b>		17. INFORMANT <b>Mrs. Charles McCauley, North East, Md.</b>			
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3 Cerebral arteriosclerosis, bilateral thrombosis</b> DUE TO (b) <b>1. Bronchopneumonia right lower &amp; middle lobes</b> DUE TO (c) <b>2. Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>491X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>36-48 hrs.</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. C. Dodson</i> EXAMINER'S NAME (Type) <b>R. C. DODSON, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-15-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NorthEast METHODIST</b>		22d. LOCATION: (City, town, or county) (State) <b>NorthEast, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i> <b>JOSEPH R. GRANT, Northeast, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Grant</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

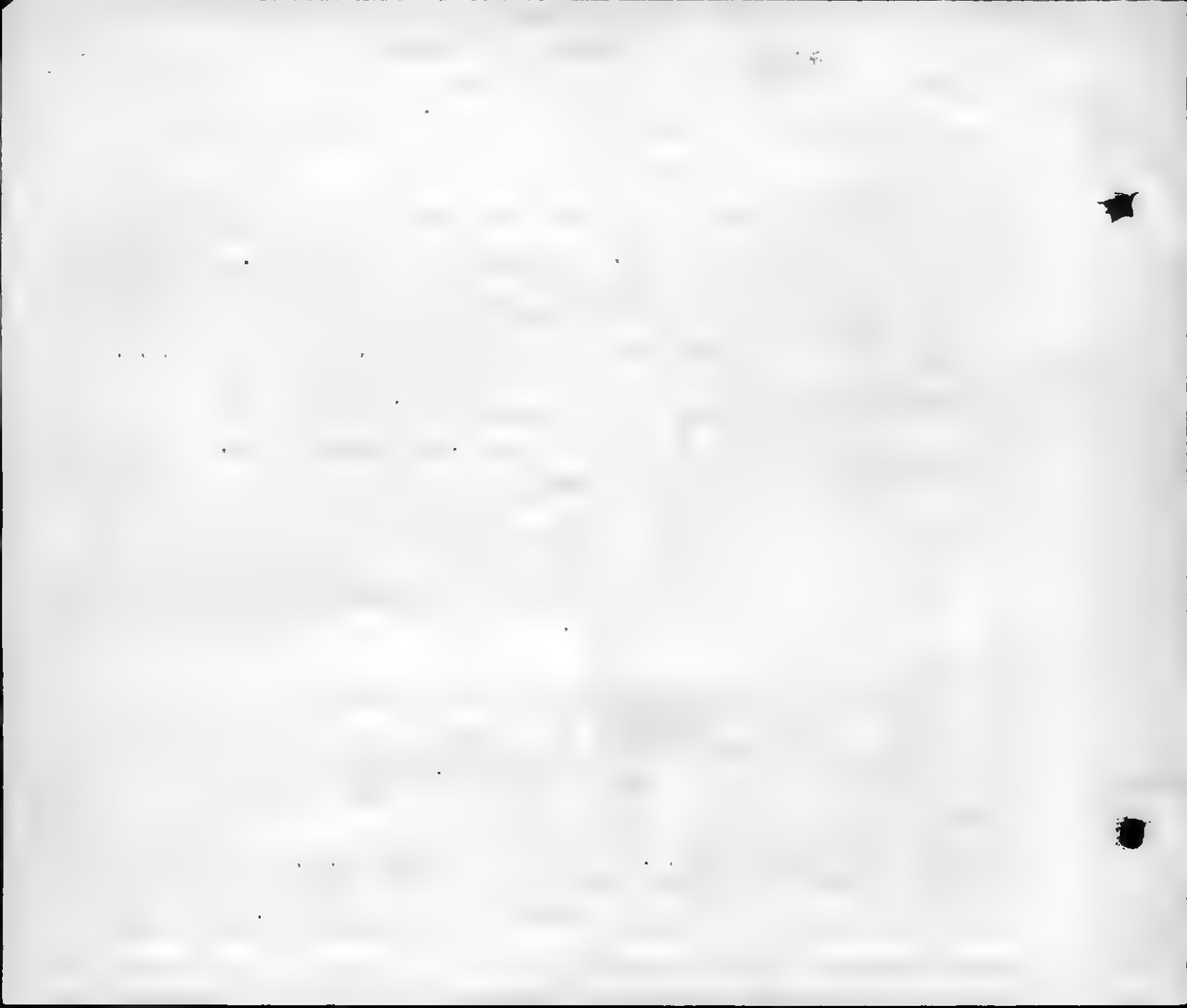
13618

CERTIFICATE OF DEATH

Reg. Dist. No.

13698

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Warwick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS <b>/</b>			
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>L.</b> Last <b>Holding</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 3, 1895</b>		9. AGE (In years last birthday) <b>64</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Chester Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Parker</b>				14. MOTHER'S MAIDEN NAME <b>Ella M. Tamey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>George R. Holding Warwick Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old CVA (cerebro-vascular accident)</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Completely paralyzed left side.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 18 Dec 59</b> to <b>18 Dec 59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>18 Dec 59</b> , 19 <b>59</b> , and that death occurred at <b>12:00 noon</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>21 Dec 59</b>							
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.				PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b> <b>Cecilton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Galena Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galena Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b> <b>Millington, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 24 1959</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Kline</b>	



13632 **CERTIFICATE OF DEATH**

13649

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North East</u>		LENGTH OF STAY (in this place) <u>25 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural North East</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS -				STREET ADDRESS (If rural give location) /			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Rudolph E. Jernstrom</u>				<b>4. DATE OF DEATH</b> (Month) <u>12</u> (Day) <u>19</u> (Year) <u>1959</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>6-25-1902</u>		<b>9. AGE last birthday</b> <u>57</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Building</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Finland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Anders W. Jernstrom</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eva Nyberg</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-18-2696</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hilma Leivonen Jernstrom North East, Md</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH (1) hour	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Aortic Insufficiency</u>						(9) months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Hypertrophy of Heart</u>						(9) months	
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>None</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>March 3, 1959</u>, to <u>Dec. 19, 1959</u>, that I last saw the deceased alive on <u>Dec. 11 1959</u>, and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James L. Jenson</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. 245 E. High, St. Elkton, Md.</u>			
<b>DATE SIGNED</b> <u>12/21/59</u>							
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-23-1959</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>North East Methodist</u>		<b>LOCATION</b> (City, town, or county) (State) <u>North East, Cecil Co., Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Knap</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant</u>		<b>ADDRESS</b> <u>North East, Maryland</u>	
<b>DATE</b> <u>DEC 23 '59</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 45C 1-55 10M





## CERTIFICATE OF DEATH

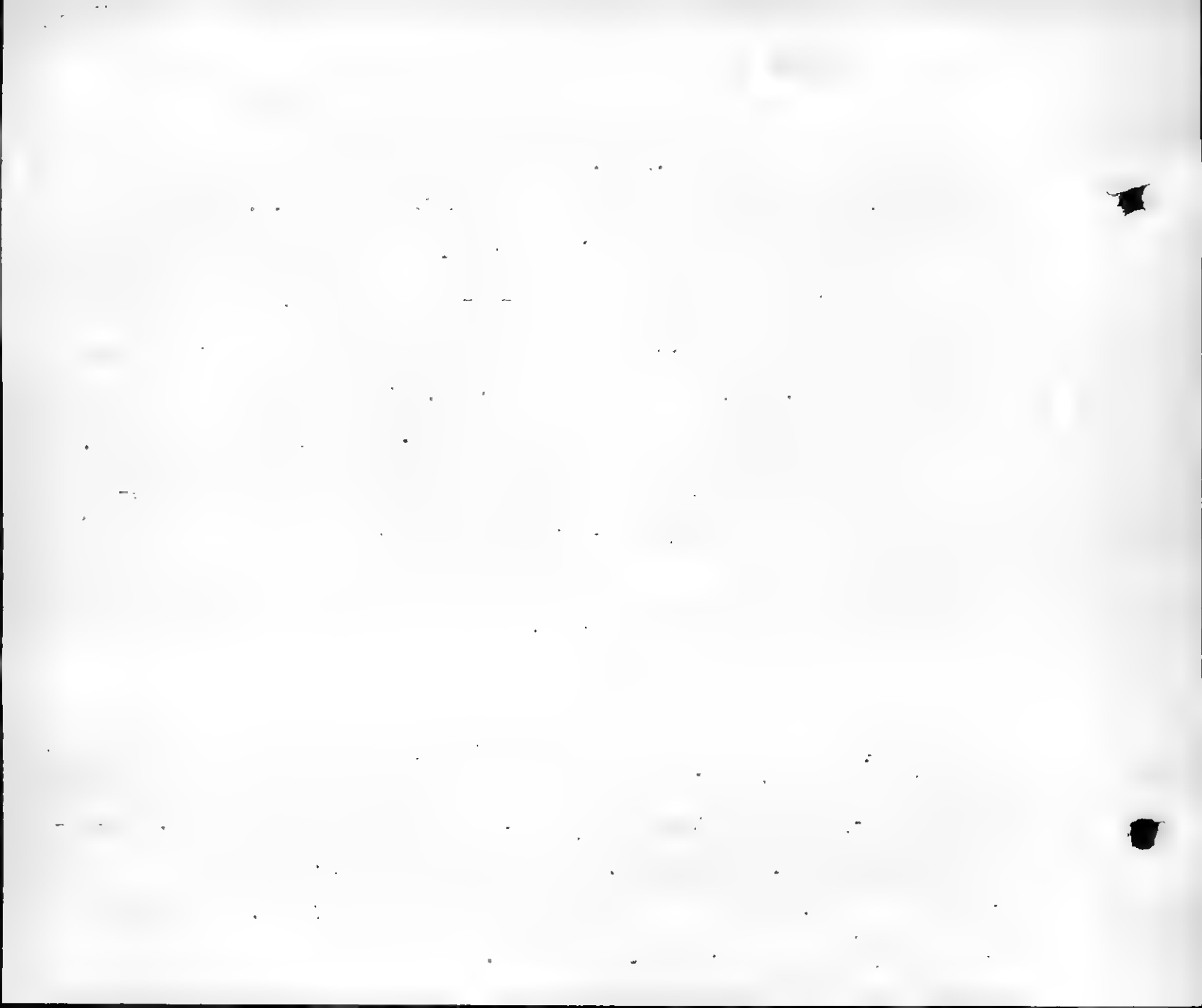
Reg. Dist. No. 96

13633

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>2yrs. 10mo. 22d</u>				d. STREET ADDRESS <u>1231 R. Street, N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>GUY</u> Middle <u>(NMI)</u> Last <u>KINZER</u>		4. DATE OF DEATH		Month <u>December</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-88</u>		9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Kinzer</u>				14. MOTHER'S MAIDEN NAME <u>Mary F. Kiyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction hemorrhagic of the heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>unknown</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>VA</u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 18, 1957</u> , to <u>December 10, 1959</u> , and that death occurred at <u>11:20 a.m.</u> , from the causes and on the date stated above. <u>XXXXXXXXXXXXXXXXXXXX</u> ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>12-11-59</u>							
ACTUAL SIGNATURE <u>J. L. Garey</u>		PHYSICIAN'S NAME (Type) <u>J. L. GAREY</u> <u>Clinical Pathologist</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>12/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington &amp; Son</u> ADDRESS <u>Havre de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>DEC 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13619

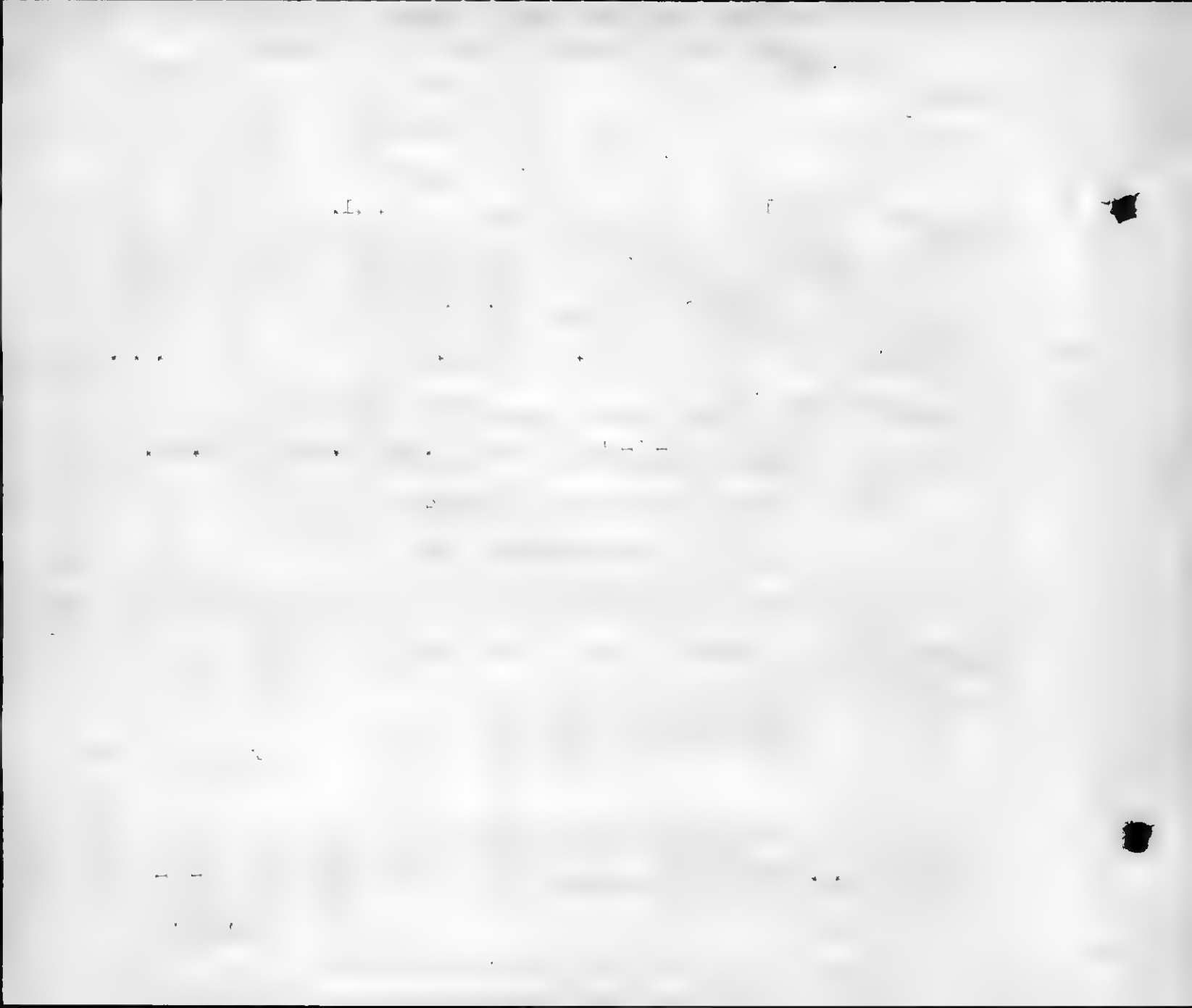
Item 3 REG-254 12-30-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> c. LENGTH OF STAY IN 1b <b>20 minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b> d. STREET ADDRESS <b>R.D.1.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Graham</b> Last <b>Thomas Knight</b>		4. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Lab.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Thomas Knight</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Allen Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>210-32-4186</b>	
17. INFORMANT (Daughter) <b>Jessie E. Burlin</b>		<b>Perryville, Md. Rural</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Atherosclerosis</b> (c), stating the underlying cause lost. DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>12-16-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-18-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Darlington</b>	22d. LOCATION (City, town, or county) (State) <b>Darlington, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13634

# CERTIFICATE OF DEATH

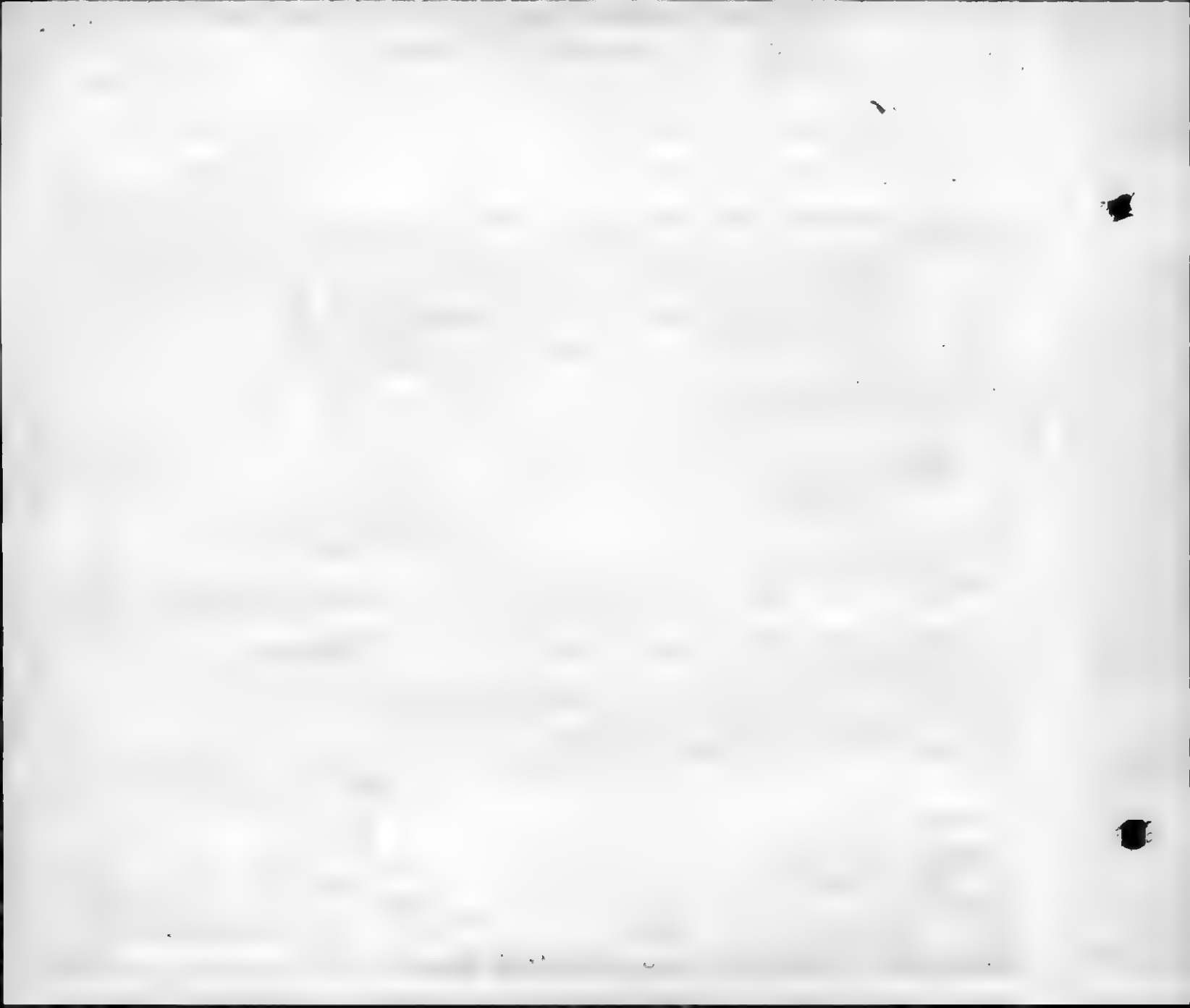
Reg. Dist. No.

13612

1. PLACE OF DEATH o. COUNTY <u>Cecil</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Cohora - Rural</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cohora - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John William Liddell</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>-3-</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1904</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Hartford Co., Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Henry Liddell</u>			14. MOTHER'S MAIDEN NAME <u>Clara H. Smith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-93</u>		17. INFORMANT <u>Miss Clara Liddell Cohora, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcosis</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Gall Bladder</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>JUL 1</u> , 19 <u>59</u> , to <u>FEB 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT 17</u> , 19 <u>59</u> , and that death occurred at <u>3:12 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. PHYSICIAN'S NAME (Type) <u>Ruby O. Left to Pearce, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/6/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>	22d. LOCATION (City, town, or county)	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. McMillan</u>		ADDRESS <u>Rising Sun, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13635**  
**CERTIFICATE OF DEATH**

13613

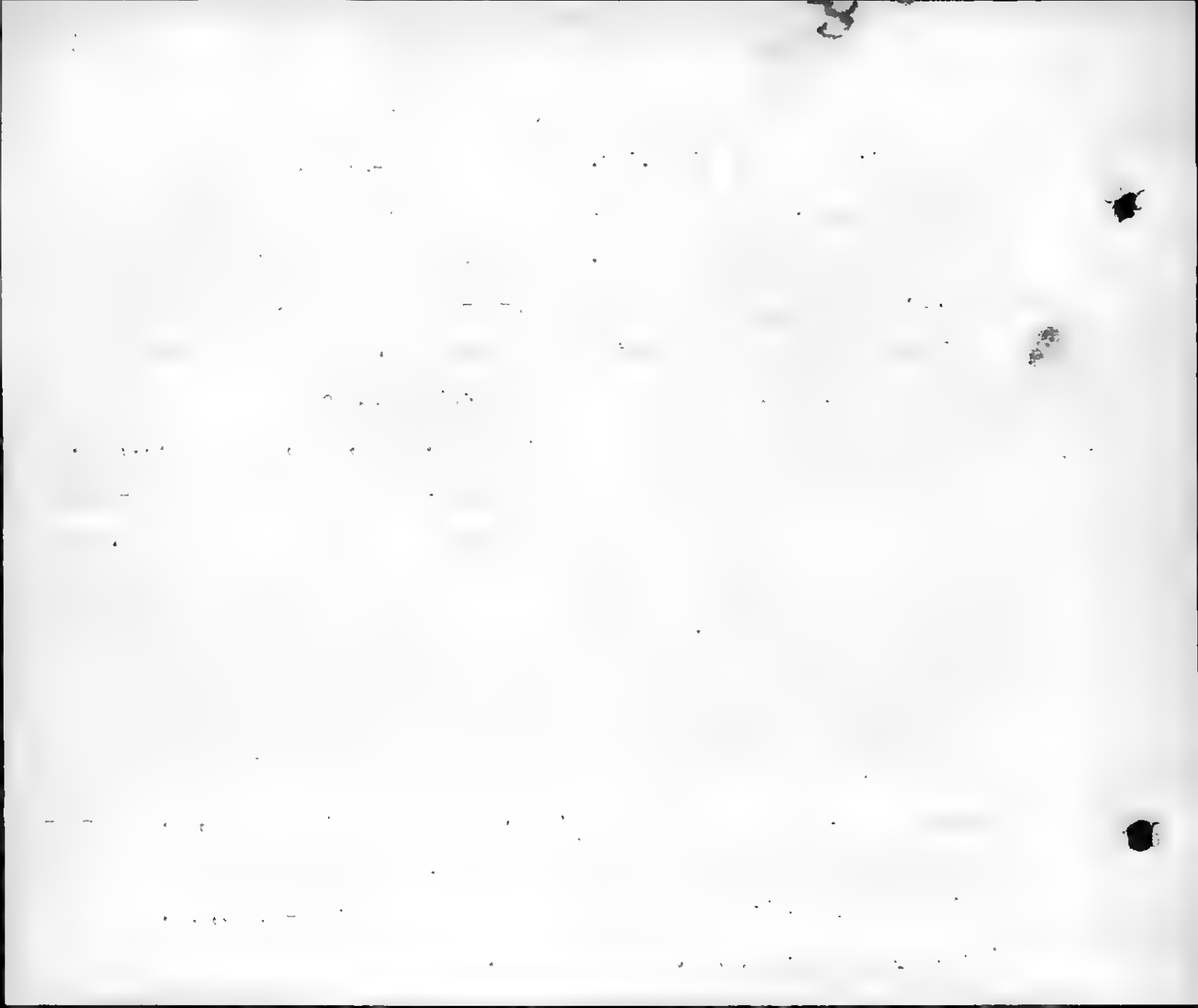
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <p align="center"><b>Cecil</b></p>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p align="center"><b>Perry Point</b></p>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <p align="center"><b>Pennsylvania</b></p>		b. COUNTY <p align="center"><b>Wilkes-Barre,</b></p>	
c. LENGTH OF STAY IN 1b <p align="center"><b>10yrs.3mo.12days</b></p>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p align="center"><b>75x</b></p>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <p align="center"><b>Veterans Administration Hospital</b></p>		d. STREET ADDRESS <p align="center"><b>312 E. Northampton</b></p>	
3. NAME OF DECEASED (Type or print) First <p align="center"><b>LOUISE</b></p>		Middle <p align="center"><b>F.</b></p>		Last <p align="center"><b>MELLIES</b></p>		4. DATE OF DEATH Month <p align="center"><b>December</b></p>	
Day <p align="center"><b>14</b></p>		Year <p align="center"><b>1959</b></p>		5. SEX <p align="center"><b>Female</b></p>		6. COLOR OR RACE <p align="center"><b>White</b></p>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <p align="center"><b>5-12-77</b></p>		9. AGE (In years lost birthday) <p align="center"><b>82 yrs</b></p>		10. IF UNDER 1 YEAR Months <p align="center"><b>82</b></p>	
11. IF UNDER 24 HRS Days <p align="center"><b>82</b></p>		12. IF UNDER 24 HRS Hours <p align="center"><b>82</b></p>		13. IF UNDER 24 HRS Min. <p align="center"><b>82</b></p>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p align="center"><b>Nurse</b></p>	
10b. KIND OF BUSINESS OR INDUSTRY <p align="center"><b>Nursing</b></p>		11. BIRTHPLACE (State or foreign country) <p align="center"><b>Pennsylvania</b></p>		12. CITIZEN OF WHAT COUNTRY? <p align="center"><b>USA</b></p>		13. FATHER'S NAME <p align="center"><b>Frederick Mellies</b></p>	
14. MOTHER'S MAIDEN NAME <p align="center"><b>Pauline Muhlic</b></p>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <p align="center"><b>Yes</b></p>		16. SOCIAL SECURITY NO. <p align="center"><b>unknown</b></p>		INFORMANT <p align="center"><b>Hospital Records, VAH, Perry Point, Md.</b></p>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <p align="center"><b>581.0</b></p>		DUE TO <p align="center"><b>Azotemia uremia (clinical)</b></p>		INTERVAL BETWEEN ONSET AND DEATH <p align="center"><b>5-6 days</b></p>		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <p align="center"><b>Cirrhosis of the liver</b></p>	
(c) <p align="center"><b>unknown</b></p>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <p align="center"><b>Arteriosclerosis generalized severe</b></p>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <p align="center"><b>VA 19</b></p>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <p align="center"><b>VA</b></p>		(County) <p align="center"><b>VA</b></p>		(State) <p align="center"><b>VA</b></p>		21. I certify that I attended the deceased from <b>September 2, 1949</b> to <b>December 14, 1959</b> and that death occurred at <b>3:00a</b> from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) <p align="center"><b>V.A. Hospital, Perry Point, Md.</b></p>		DATE SIGNED <p align="center"><b>12-14-59</b></p>		ACTUAL SIGNATURE <p align="center"><b>J. L. Garey</b></p>		PHYSICIAN'S NAME (Type) <p align="center"><b>J. L. GAREY</b></p>	
22a. NAME OF CEMETERY OR CREMATORY <p align="center"><b>Hollenback</b></p>		22b. LOCATION (City, town, or county) <p align="center"><b>Wilkes-Barre, Pa.</b></p>		22c. DATE THEREOF <p align="center"><b>12/15/59</b></p>		22d. BURIAL/CREMATION REMOVAL (Specify) <p align="center"><b>12/15/59</b></p>	
23. FUNERAL DIRECTOR'S SIGNATURE <p align="center"><b>Pennington &amp; Son</b></p>		ADDRESS <p align="center"><b>Havre de Grace, Md.</b></p>		24a. REC'D BY REGISTRAR DATE <p align="center"><b>DEC 17 '59</b></p>		24b. REGISTRAR'S SIGNATURE <p align="center"><b>Arthur S. Kraus</b></p>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

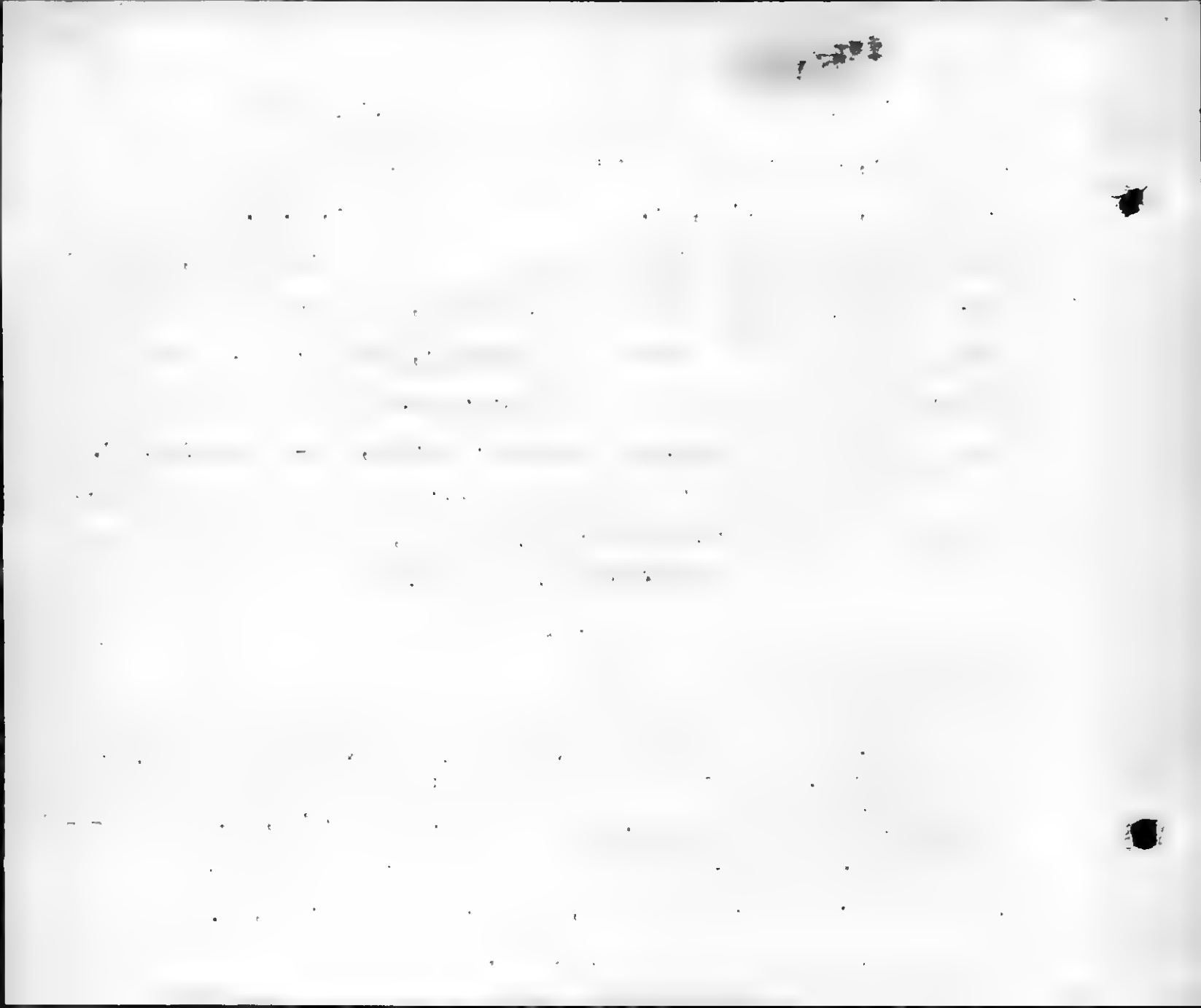
## CERTIFICATE OF DEATH

Reg. Dist. No. 96

13614

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b> c. LENGTH OF STAY IN 1b <b>51 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1245 Neal Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY MILLER</b> First Middle Last		4. DATE OF DEATH <b>December 4, 1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 5, 1895</b> 9. AGE (In years last birthday) <b>63</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>McDowell, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Milton Miller</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized, severe</b> DUE TO (c) <b>Adenocarcinoma of the prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Adenocarcinoma of the prostate</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-4-59</b> to <b>12-4-59</b> and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH., Perry Point, Md.</b> DATE SIGNED <b>12-4-59</b>			
ACTUAL SIGNATURE <b>J. L. Garey</b>		DATE SIGNED <b>12-4-59</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY, MD</b>		Clinical Pathologist.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>12/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington, National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fernington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. RECEIVED BY REGISTRAR <b>DEC 10 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No. 96

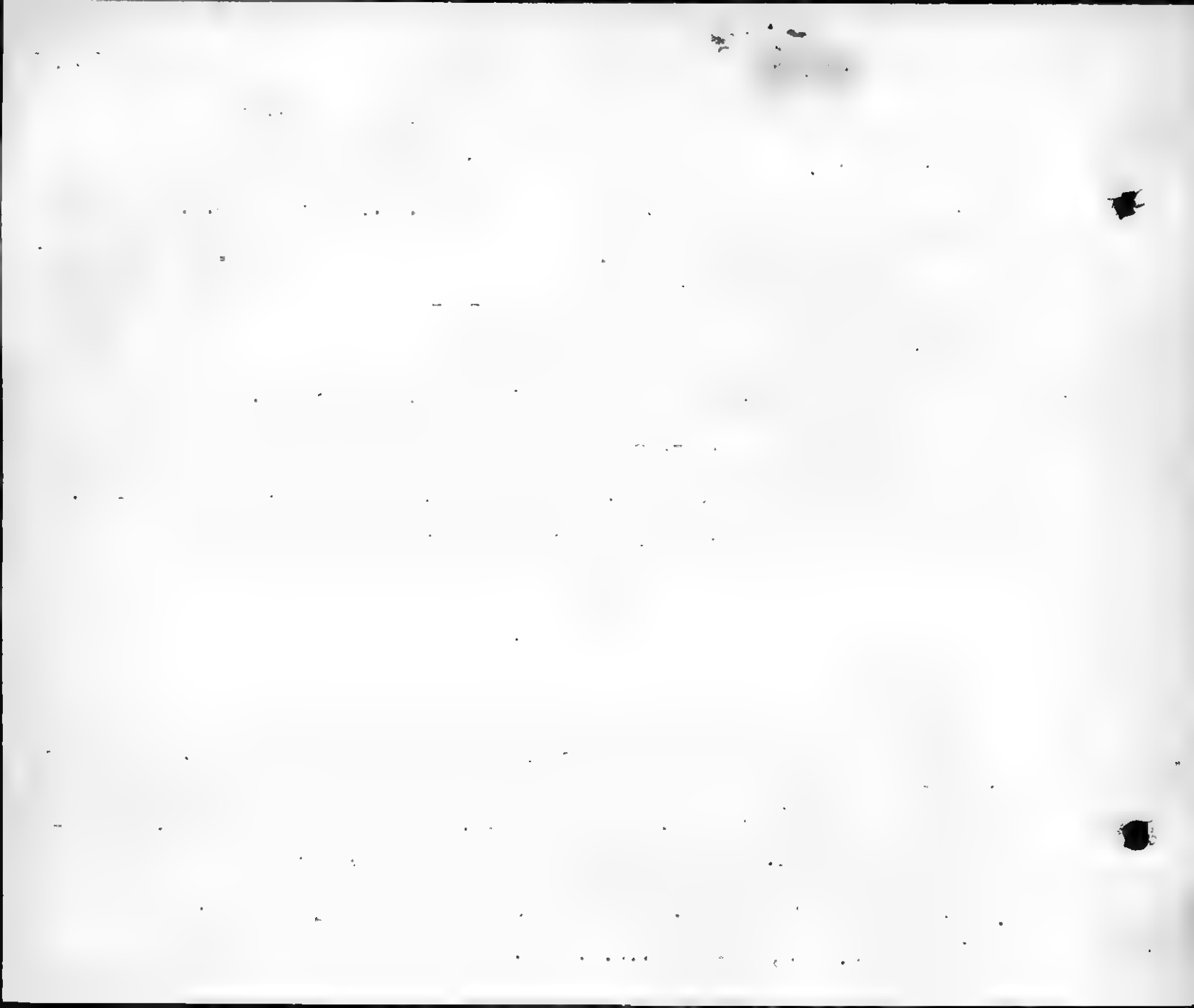
13637

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>34 days</u>		d. STREET ADDRESS <u>2711 Ft. Baker Drive, S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>M.</u> Last <u>MOORE</u>		4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>19 59</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-87</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Book Binding</u>	
11 BIRTHPLACE (State or foreign country) <u>Texas</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ransome Moore (Deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Martha E. Moroney (Deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>486-10-4286</u>	
17. INFORMANT <u>Hospital Records, VAH, Perry Point, Md.</u>		Address <u>Hospital Records, VAH, Perry Point, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, left lower lobe, unresolved</u> 4:20.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis generalized severe</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>VA</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 18, 1959</u> , to <u>December 22, 1959</u> , that I saw the deceased alive on <u>November 18, 1959</u> , and that death occurred at <u>4:15 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>12-23-59</u>			
ACTUAL SIGNATURE <u>J. L. Garey</u>		M.D. <u>V.A. Hospital, Perry Point, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. L. GAREY</u>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Fun. Home, 517-11th St. S.E. Wash. DC</u>		24a. REGISTERED REGISTRAR <u>28 59</u> DATE <u>12-28-59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 5254 1-14-65 et

13638

## CERTIFICATE OF DEATH

Reg. Dist. No.

13616  
96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1127 Fifth Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>A.</b> Last <b>ORMES</b>		4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-73</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>86</b>	11. IF UNDER 24 HRS Hours <b>86</b> Min. <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd Jobs</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not ascertainable</b>		14. MOTHER'S MAIDEN NAME <b>Not ascertainable</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral unresolved</b> DUE TO (b) <b>Osteogenic sarcoma with chest metastasis, spleen and gall bladder</b> (c) <b>Atherosclerosis of aortic &amp; mitral valves with stenosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis of coronary artery without cardiac symp-</b> toms			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>toms</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 8, 1937</b> , to <b>December 17, 1959</b> , and that death occurred at <b>1:12 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>12-18-59</b>			
ACTUAL SIGNATURE <b>Louis G. Cian</b>		PHYSICIAN'S NAME (Type) <b>LOUIS G. CIAN</b> Staff Surgeon	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>12/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Remington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

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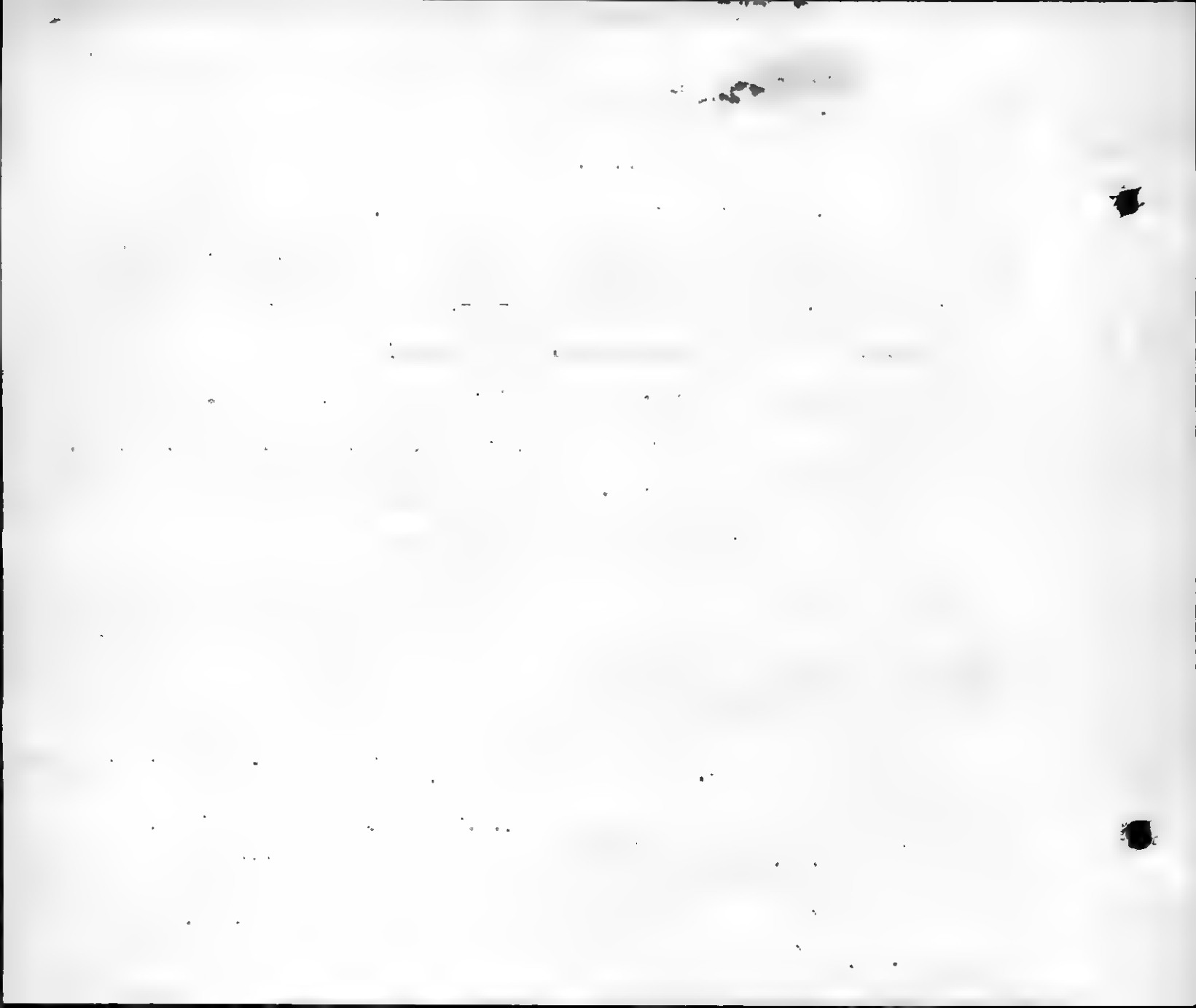
## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>11yrs. 1mo. 9days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Virginia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>202 S. Fayette</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES (NMI) SIBERT</b>		4. DATE OF DEATH Month Day Year <b>December 14 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-84</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not available in records</b>		14. MOTHER'S MAIDEN NAME <b>Not available in records</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4x0.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis generalized</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 5, 1948</b> , to <b>December 14, 1959</b> , that last saw the deceased on <b>December 14, 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>J. L. Garey</b> M.D. <b>V.A. Hospital, Perry Point, Md.</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b> Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>12/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Penningson &amp; Son</b>		24a. REC'D BY REGISTRAR <b>DEC 29 59</b>	
ADDRESS <b>Havre de Grace, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hensch</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

14357

Reg. Dist. No.

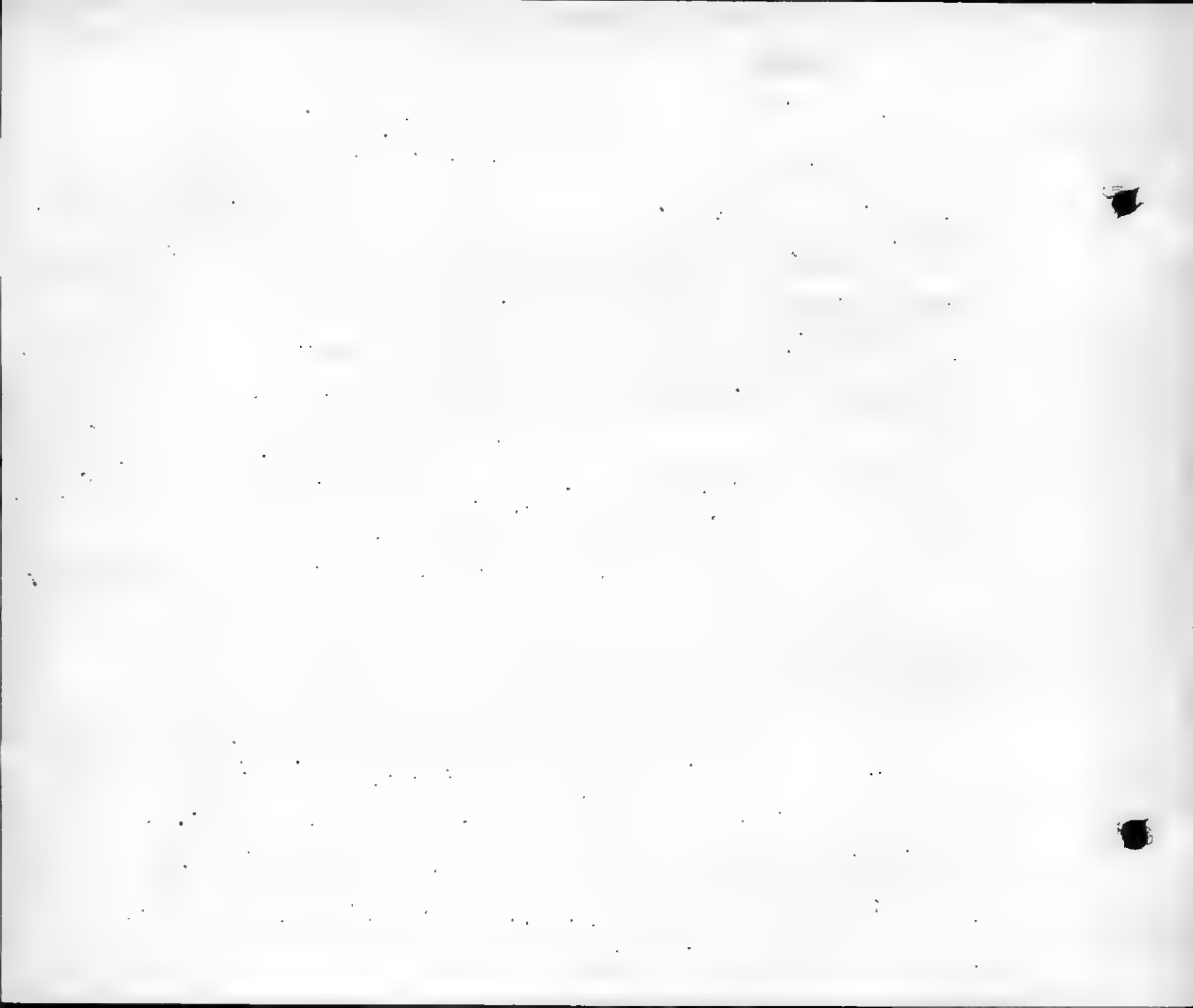
13620

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> d. STREET ADDRESS <u>151 West High St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Waniel Z Simmons</u> First Middle Last		4. DATE OF DEATH <u>Dec 27 1959</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1883</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter - Ship</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Elisa Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Anna R. Simmons - wife</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4 <u>arterio Sclerosis</u> DUE TO (b) <u>Suprapubic Prostatectomy</u> DUE TO (c) <u>Dec 27/59</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 8, 1959</u> to <u>Dec 27, 1959</u> that I last saw the deceased alive on <u>Dec 27, 1959</u> and that death occurred at <u>10:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Arthur Cantwell</u> M.D.		ADDRESS (Street, city or town, state) <u>North East, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>H. Arthur Cantwell</u>		<u>North East, Md.</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12/30/59</u>	<u>Elkton Cemetery</u>	<u>Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks, Elkton, Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>
		DATE <u>JAN 6 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove棺盖 papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13618

13640

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Buckley Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun	
3. NAME OF DECEASED (Type or print) First MINNIE Middle E. Last STOUGH		4. DATE OF DEATH December 20 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1894
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) York County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Eisenhower		14. MOTHER'S MAIDEN NAME Sarah Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Harold R. David		Address Rising Sun, Md. 17 Buckley Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction DUE TO (b) Acute thrombophlebitis DUE TO (c) Peripheral vascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 days 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bed ridden due to hip fracture		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5, 1958, to 12/20, 1959, that I last saw the deceased alive on 12/20, 1959, and that death occurred at 3:40 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor M.D.		DATE SIGNED 12/20/59	
PHYSICIAN'S NAME (Type) Neil Taylor Jr		Rising Sun, Md. 12/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23 1959	
22c. NAME OF CEMETERY OR CREMATORY Shiloh Union Cemetery		22d. LOCATION (City, town, or county) York County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Clark Tyson		ADDRESS, Rising Sun, Md.	
24a. REC'D BY REGISTRAR DATE DEC 22 '59		24b. REGISTRAR'S SIGNATURE	



13621

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eikton</b>		c. LENGTH OF STAY IN TB <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clauss</b> Middle Last <b>Tassick</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <b>Unknown</b>	8. DATE OF BIRTH <b>1892</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Work</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b> ✓	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>O.B. Wilson</b>		Address <b>Colora, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b>							<b>3 days</b>
446X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Uremia</b>							<b>2 wks</b>
DUE TO							
(c) <b>Nephrosclerosis</b>							<b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>Generalized Arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>5 Dec. 1959</b> to <b>7 Dec. 1959</b> , that I last saw the deceased alive on <b>7 Dec. 1959</b> , and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Klaus H. Huebner</b>				ADDRESS (Street, city or town, state) <b>North East, Md.</b>		DATE SIGNED <b>7 Dec '59</b>	
PHYSICIAN'S NAME (Type) <b>Klaus H. Huebner</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		22d. LOCATION (City, town, or county) (State) <b>Colora Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>				ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6254 1-4-60 et

13622

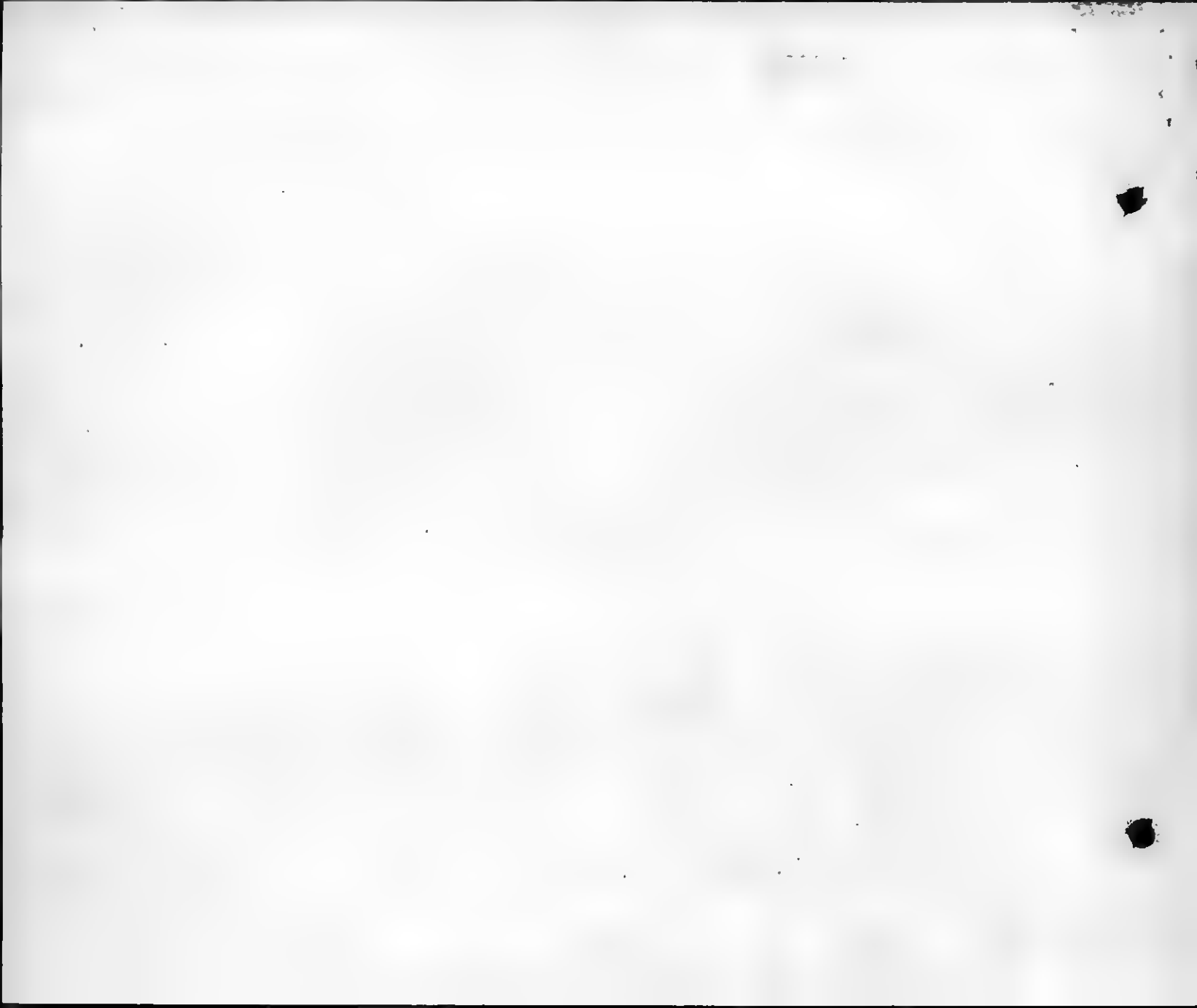
## CERTIFICATE OF DEATH

Reg. Dist. No.

13620

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>21</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Clara</u> Middle <u>Thompson</u> Last <u>Thompson</u>		<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Martha Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO <u>218-38-3744</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Parencephalitis, Nephritis</u> DUE TO (c) <u>Aortic Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10 Years</u> <u>10 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>June 9</u> , 19 <u>59</u> , to <u>December 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 17</u> , 19 <u>59</u> , and that death occurred at <u>2 A</u> :M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>245 East High Street</u> <u>Elkton</u> , <u>Maryland</u>			
ACTUAL SIGNATURE <u>James L. Johnson</u> M.D.		DATE SIGNED <u>12/18/59</u>	
PHYSICIAN'S NAME (Type) <u>James L. Johnson M. D.</u>		ADDRESS <u>Elkton</u> , <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Providence Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer P. Bell</u>		ADDRESS <u>909 Poplar St.</u>	
24a. REC'D BY REGISTRAR <u>DEC 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



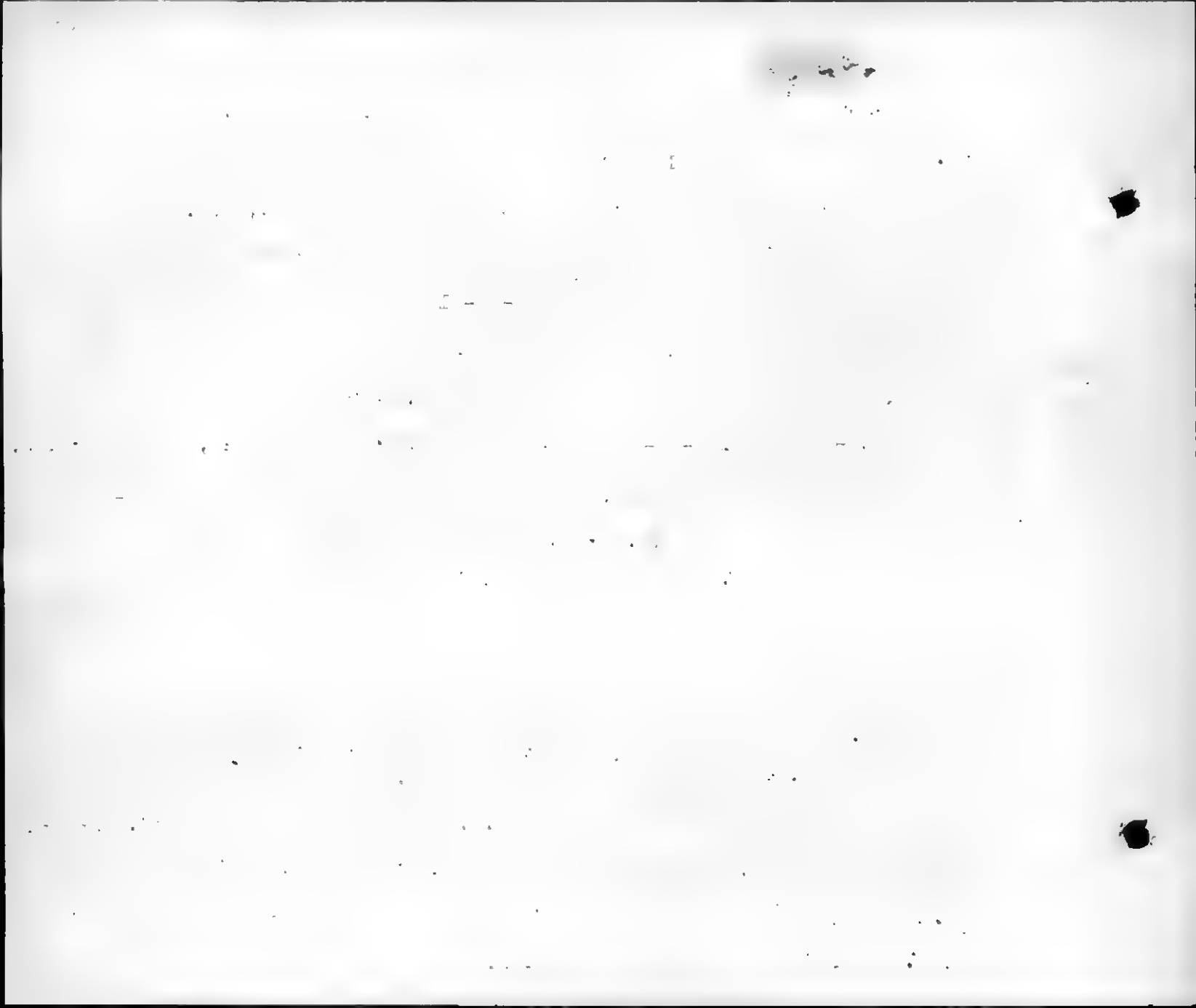


13641

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>1</b> days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1817 Adams Mill Road, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>QUINCY</b> Middle <b>SUE</b> Last <b>TING</b>		4. DATE OF DEATH Month <b>December</b> Day <b>10,</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Yellow</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-26-91</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	11. IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Head Waiter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Que Duck</b>		14. MOTHER'S MAIDEN NAME <b>Jont Shee Quon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I 123-10-0537</b>	
17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>463X Bronchopneumonia bilateral, unresolved</b> DUE TO (b) <b>Thrombophlebitis left femoral vein</b> DUE TO (c) <b>Gangrene of the left lower extremity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 9, 1959</b> , to <b>December 10, 1959</b> at <b>VA Hospital, Perry Point, Md.</b> that death occurred at <b>6:26 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>12-11-59</b>			
ACTUAL SIGNATURE <b>J. L. Garey</b>		PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>12/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>	
ADDRESS <b>Havre DeGrace, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. Thraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 8 & 9, Film G-254 1/12/60.cac.

13622

CERTIFICATE OF DEATH

Reg. Dist. No.

13642

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VA Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>W.</b> Last <b>WHITLOCK</b>		4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-87 1-24-88</b>
9. AGE (In years last birthday) <b>72 1/2</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>1</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>12</b> Days <b>1</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Earlville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES WHITLOCK</b>		14. MOTHER'S MAIDEN NAME <b>Susie Chambers.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-10-8267</b>	
17. INFORMANT <b>Hospital records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia Bilateral, Unresolved</b> 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Monocytic Leukemia</b> DUE TO (c) <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis - Generalized.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> P. <b>VA</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that death occurred at <b>12:12 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Maryland</b> DATE SIGNED ACTUAL SIGNATURE <b>J. L. Garey</b> M.D. PHYSICIAN'S NAME (Type) <b>J. L. GAREY, MD</b> <b>Clinical Pathologist</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Pippin</b> ADDRESS <b>PIPPIN FUNERAL HOME, Elkton Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 15 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hearn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION

Date

Referred to

Serial

Mr. [Name]

Page 1

John [Name], [Address]

Mr. [Name]

Received by

Mr. [Name]

1-1-37

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13623**

**13643**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;">b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b></span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span>											
c. LENGTH OF STAY IN 1b <b>all life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecilton</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>STREET ADDRESS</b>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Alexander</b> Middle <b>Wilson</b> Last <b>Wilson</b>				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>9</b> Year <b>19 59</b>											
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>C</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 1876</b>		<b>9. AGE</b> (In years last birthday) <b>83</b> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.		
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Months	Days	Hours	Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Ordinary work</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Cecil Co. Md.</b>											
<b>13. FATHER'S NAME</b> <b>Charles Wilson</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Brown</b>												
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> <b>Annie Wise Cecilton, Md.</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Acute Coronary Occlusion</b>  <b>420.1</b> DUE TO             </td> <td rowspan="3" style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> </tr> <tr> <td colspan="2"> <b>(b)</b> <b>Arterio Sclerosis Extreme</b>  <b>DUE TO</b> </td> </tr> <tr> <td colspan="3"> <b>(c)</b> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>		<b>(b)</b> <b>Arterio Sclerosis Extreme</b> <b>DUE TO</b>		<b>(c)</b>		
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<b>(c)</b>															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Hour <b>19</b> o. m. p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>										
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/> . <b>Actual Signature:</b> <i>M. C. Dodson</i> <b>M.D.</b> <span style="float: right;"><b>DATE SIGNED</b> <b>12-9-59</b></span>															
<b>EXAMINER'S NAME</b> (Type) <b>B. C. Dodson M.D.</b>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>													
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>12/12/59</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cecilton Cem.</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>Cecilton Md.</b>												
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Edw. R. Bell</i>		<b>ADDRESS</b> <b>909 Poplar St.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE DEC 14 '59</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Knaus</i>										

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

